EXHIBIT 7

EMPLOYEE ASSISTANCE AGREEMENT

I acknowledge that this agreement is an expression of Home Depot's sincere interest in my well-being. Home Depot is committed to putting forth sufficient effort to establish an atmosphere that is supportive of recovery in the workplace. In return, I agree to comply with the terms of this agreement, as an aid towards recovery, not punishment.

In following with Home Depot's Substance Abuse Policy, which I have read and understand, I agree to the following conditions of my continued employment:

1. I agree to schedule an assessment/evaluation within 48 hours of signing this agreement. (I understand I should contact the CARE Program at (800) 553-3504 for an assessment). In addition, I understand that I will not be allowed to return to work until after completion of the assessment, a return to work release from the Substance Abuse professional is provided and a return to work drug test is passed.
2. I agree to sign a release authorizing The Home Depot or Magellan Behavioral Health to receive written and verbal verification that I have been for an assessment/evaluation and also provide information about the:
   - type of recommended treatment (if any is recommended)
   - schedule and length of the treatment program, and
   - successful completion of any recommended treatment program
3. I agree to fully comply with the treatment recommendations and with the rehabilitation program as outlined by the Substance Abuse Professional.
4. I will be subject to periodic drug and/or alcohol testing during the remainder of my employment at Home Depot whether the Company has reasonable suspicion or not to believe drug or alcohol abuse occurred at work or has affected my work performance (unless state law designates specific limits to such testing).
5. If I refuse to take a required drug and/or alcohol test or fail a drug and/or alcohol test at any time during the course of my employment at Home Depot, I will be immediately terminated.

I acknowledge that I have read and understand the terms of this agreement. I understand that this agreement in no way constitutes a commitment by the company to pay for, or assist in paying for, any portion of necessary treatment. I further understand that no contract of employment is or has been created between Home Depot and myself. I have the right to terminate my employment at any time, with or without cause or reason. Home Depot has the same right.

Social Security # [redacted]

Location # 1975

Today's Date 9-23-06

Addiction Type (CIRCLE ONE): Drug / Alcohol / Both

Associate Name (Please Print): DIANE AMES

Associate Signature: Diane L. Ames

Management Name (Please Print)

Management Signature

20060918000001784-001-0001

Magellan Case #

FAX a copy of the signed Employee Assistance Agreement to Magellan at (800) 848-5681. Keep the original Employee Assistance Agreement in the associate's medical file. NEVER put the agreement or other treatment information in the associate's personnel file.

rev-September 2006

DA0074

MAGELLAN HEALTH SERVICES

Authorization to Use or Disclose Protected Health Information (PHI)

(Employer Referral Case)

1. MEMBER INFORMATION

I, DIANE AMES 20060918060001784-001-0001 [redacted]60

(Client Name) (Magellan Case No.) (Date of Birth - MM/DD/YYYY)

[redacted] [redacted] IL 60560

(Address) (City) (State) (Zip Code)

hereby give permission to Magellan Health Services or any of its subsidiaries or affiliates ("Magellan") and the Magellan staff performing services in connection with my treatment to: either disclose information to each of the following and/or obtain information from each of the following: *(check one or both boxes)*:

☒ ☐

Michael Mahon/Bea Kelly *and the successor or designee of Company Contact* **Home Depot**

(Name and Job Title of Company Contact) *(Company Name)*

(Name of Provider)

2. PURPOSE OF USE OR DISCLOSURE

☒ To verify whether I am participating in and cooperating with the EAP, as suggested by my employer. **(Formal Referral)**

☐ Other *(specify)*: _____

3. PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED

Only the following information (*Client MUST INITIAL each item to be disclosed*):

☒ (DA Initial) Current status (compliant or non-compliant) ☐ (___Initial) Substance Abuse Evaluation ☒ (DA Initial) Treatment Plan

☐ (___Initial) Attendance Records Only. ☒ (DA Initial) Progress Report on my Treatment ☐ (___Initial) Drug/Alcohol Test Results

☒ (DA Initial) Expected Length of Treatment ☐ (___Initial) Diagnosis/Assessment

☐ (___Initial) - Other (specify information to be disclosed and any restrictions) _____

4. EXPIRATION OF AUTHORIZATION *(check one)*

☐ This date (no more than 1 year from today): _____

☐ This date – 90 days from today [Washington state – all cases]: _____

☐ 6 months after my EAP case is closed.

5. YOUR RIGHTS

- You can end this authorization at any time by writing to Magellan Health Services, Workplace Support, 14100 Magellan Plaza, Maryland Heights, MO 63043. If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission, or end Magellan's ability to confirm information already disclosed in a legal proceeding. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- Magellan does not condition treatment, payment, enrollment, or eligibility on your signing this form.
- You do not have to agree to this request to use or disclose your information.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.

6. RE-DISCLOSURE BY RECIPIENT

Except as described below, information that is disclosed as a result of this Authorization Form may be subject to re-disclosure by the recipient and no longer protected by law. Magellan has to follow laws that protect your health information, but not all persons or organizations have to follow these laws.

If you have questions about anything on this form, call to speak to a Customer Service Representative: 1-877-326-7525.

7. SIGNATURES

(Do not sign until all checked boxes above are initialed)

Diane Ames 9-23-06 OR _____ 9/23/06

(Signature of member) (Date) (Authorized representative if required) (Date)

If signed by authorized representative, describe authority to act for member:

NOTICE TO RECIPIENT OF INFORMATION

Information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUD/Midwest CMC PR/040105

DA0073